Billed Amounts

Providers are required to bill for each date of service that care was provided.

Providers are required to bill their usual and customary charge for services provided. Refer to the General Information section of this handbook for more information on reimbursement.

Billing Dates of Service

Providers are required to bill for each date of service that care was provided. When billing, a maximum of four dates of service may be entered on one detail line, given the following conditions:

- All dates of service are in the same calendar month.
- Procedure codes are the same for all four dates of service.
- The charges for the procedures are identical for each date of service.
- The quantity of units is the same for all dates of service.

The quantity entered for each detail line represents the number of units for each day, multiplied by the number of days of service. Similarly, the charges for each detail line represent the charges for that service multiplied by the number of days of service. Refer to Appendix 3 of this section for an example of series billing.

If two or more detail lines must be used for the same procedure/revenue code (e.g., when billing more than four identical dates of service in a calendar month), the additional dates of service that can be billed to the same procedure/revenue code must be indicated on a separate detail line. The appropriate units and charges for those dates of service must also be included.

Each detail line must always include the correct units and charges for the dates on that line or the claim will be denied.

Billing Units of Service

Personal Care and Travel Time

For personal care services and travel time, one hour of service is equivalent to one unit of service and one-half hour of service is equivalent to one-half unit of service. Personal care providers should bill in one-half hour increments.

When calculating the number of units that should be billed (Item 46 on the UB-92 claim form), total the number of personal care hours or travel time hours for that date of service, and round up or down according to the following guidelines:

- If the time spent giving care is a maximum of 1 to 30 minutes in length, round the time up to 30 minutes and bill the service as a quantity of 0.5 unit.
- If the time spent giving care is more than 30 minutes in length, then round up or down to the nearest 30-minute increment using the common rules of rounding.

Follow the same rounding rules when calculating travel time. Refer to Appendix 4 for a chart of rounding guidelines. Refer to the Covered Services chapter of the Covered Services section of this handbook for more information on travel time.

Registered Nurse Supervisory Visits

Registered nurse supervisory visits for personal care (procedure codes W9906 or W9044) must be billed as a quantity of one unit, regardless of the duration of the visit. For example, a supervisory visit lasting 20 minutes and a supervisory visit lasting 60 minutes would both be billed a quantity of 1. Refer to the Covered Services section of this handbook for more information on personal care supervisory visits.

Procedure Codes

All Personal Care Services

Providers are required to use Wisconsin Medicaid procedure codes (W codes) to bill personal care services, travel time and RN supervisory visits. Refer to Appendix 4 for a current list of allowable procedure codes and descriptions. Claims or adjustments received without the appropriate codes are denied.

Disposable Medical Supplies

Providers are required to use the HCFA Common Procedure Coding System (HCPCS) codes for billing disposable medical supplies (DMS). Covered DMS codes can be found in the DMS Index, which is sent to providers periodically, or on the Wisconsin Medicaid web site at *www.dhfs.state.wi.us/medicaid*. Claims or adjustments received without the appropriate codes are denied.

Billing Place of Service and Type of Service on Claim Form

UB-92 Claim Form

Personal care services are billed on the UB-92 claim form. Place of service (POS) and type of service (TOS) codes are not required. However, providers should keep in mind that place of service and type of service codes are required on the Prior Authorization Request Form (PA/RF), elements 16 and 17.

HCFA 1500 Claim Form

Use the HCFA 1500 claim form to bill DMS. Both place of service and type of service codes are required. Refer to Appendix 4 for allowable place of service and allowable type of service codes.

Providers are required to use Wisconsin Medicaid procedure codes (W codes) to bill personal care services, travel time and RN supervisory visits.